Calendar No. 422

100TH CONGRESS *1st Session* | SENATE | REPORT 100-212

ESTABLISHING AN EFFECTIVE CLINICAL STAFFING RECRUITMENT AND RETENTION PROGRAM, AND FOR OTHER PURPOSES

NOVEMBER 4 (legislative day, OCTOBER 16), 1987.—Ordered to be printed

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Mr. INOUYE, from the Select Committee on Indian Affairs, submitted the following

REPORT

together with

MINORITY VIEWS

[To accompany S. 1475]

The Select Committee on Indian Affairs, to which was referred the bill (S. 1475) to establish an effective clinical staffing recruitment and retention program, and for other purposes, having considered the same, reports favorably thereon with an amendment and recommends that the bill as amended do pass.

The amendment is an amendment in the nature of a substitute.

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I. Purpose and Summary

The purpose of S. 1475 is to direct the Secretary of Health and Human Services, acting through the Indian Health Service, to establish and implement a staff recruitment and retention program which will ensure an adequate supply of clinical staff for the Indian Health Service.

The major provisions of the bill are: (1) A loan repayment program which would authorize the IHS to recruit health professionals and secure written contracts for repayment of student loans, up to $25,000 per year, in exchange for each year of obligated service; (2) Programs to enchance recruitment and retention of personnel which include; (a) reimbursement of travel expenses for recruitment of health professionals and their spouses, (b) grants for tribal demonstration recruitment projects, (c) local educational programs on tribal history and culture for IHS personnel, (d) maintenance of the INMED Program model at the University of North Dakota and expansion of the INMED model in two other regional sites, (e) grants for establishing health training programs in local or tribal community colleges, (f) a program to enable health professionals who have consistently worked for the IHS to take leave to pursue advance training or research which is advantageous to the IHS, (g) additional incentives for employees which include a retention bonus for employees who commit to additional years of service after three years, (h) a demonstration project which utilizes foreign medical graduates, and (i) an advisory panel of health professionals to review and report on policies and procedures, including pay scales, which impede recruitment and retention. The bill also authorizes appropriations to carry out the provisions of the act.

II. Background and Need

S. 1475 addresses major problems in clinical staffing within the Indian Health Service. Presently, the IHS has a 10–20% shortage of staff which is predicted to increase unless recruitment and retention of IHS personnel can be substantially improved. With termination of the National Health Service Corp (NHSC) scholarship program, which has been a major source of physicians and other health care professionals for the IHS, the number of physicians available to the IHS will be severely diminished. A special report prepared by the Office of Technology Assessment (OTA) in February 1987, "Clinical Staffing in the Indian Health Service," indicates that after 1988 the rapid decline of physicians will severely limit the ability of the Indian Health Service to deliver health care to American Indians and Alaska Natives.

An increased shortage of staff is predicted to have several adverse effects upon the delivery of health care to nearly 1 million American Indians served by IHS. First and foremost, a shortage of clinical staff will reduce the Service's ability to provide direct care at IHS facilities. Second, referrals to non-IHS facilities with a corresponding increase in contract health care budgets will dramatically affect a budget item which is already chronically under funded. Shortages of clinical staff would also increase overtime requirements by existing staff, contributing to employee "burnout" and subsequent increases in the employee attrition rate. All of

these effects would reduce the quality and quantity of health care provided by the Indian Health Service.

Traditionally, it has been difficult for the IHS to recruit and retain health professionals because of low salaries, facilities constraints, and rural isolation factors which are associated with IHS facilities located on reservations. The major disincentive to IHS employment is low physician salaries which are not competitive with those offered by other providers. For example, IHS can pay about $45,000 to hire a new 3-year resident physician, as compared to $60,000 to $100,000 in the private sector. When comparing salaries with the Veterans Administration the disparity is nearly $21,000 per year as VA physicians can make $66,870 per year at entry level. At one time IHS could offer benefits, i.e. malpractice insurance, which exceeded other groups; but with the recent growth of health maintenance organizations, IHS faces stiff competition.

Other organizational disincentives include small, limited-service hospitals, inadequate equipment and support staff, and shortages of professional staff that can lead to overwork and heavy on-call schedules. Further, the extreme geographic isolation of some IHS sites is associated with lack of housing, schools and other services.

In its total workforce of approximately 10,400 (1985), IHS employs about 750 physicians, nearly 2,000 professional nurses, 800 practical nurses, 300 pharamacists, and 275 dentists. IHS staff may be hired through either of two personnel systems, the Federal civil service or the PHS Commissioned Corps.

For many years, IHS has operated its own physician recruiting program. This program has never been large or well-staffed at the headquarters level, and it has relied on part-time IHS area office recruiters for additional support. At the end of the doctor draft, which allowed physicians subject to military draft to serve in alternative IHS placements, IHS experienced a shortfall in recruiting physicians on a voluntary basis that graudually was filled in the late 1970s and 1980s by physicians from the National Health Service Corps (NHSC). NHSC physicians are obligated to serve from 1 to 4 years in health manpower shortage areas, which include IHS sites, in order to pay back their medical scholarships. The NHSC has been responsible for recruiting approximately 60 percent of the IHS clinical providers.

During the last 6 years the NHSC has been gradually phased out (from over 6,000 scholarships offered in 1982 to fewer than 50 in 1986). The phase-out was prompted by the Administration because of the "surplus of physicians" which, theoretically, should make recruitment of volunteers easier for the Public Health Service and the Indian Health Service. However, the OTA noted that the surplus of physicians is in specialty areas while IHS needs general and family practitioners, and that, rural areas of the country have not found the "physician surplus" to help in their recruitment efforts. For reasons cited previously, IHS is at a disadvantage with even rural areas in competing for physicians. Recently, IHS has been able to recruit 40 to 50 voluntary physicians annually; but its ability to recruit enough volunteers to replace lost NHSC physicians has not been tested.

Anticipating the loss of NHSC physicians, IHS has stated its ultimate objective which is to recruit and retain an all-volunteer professional staff. During 1986, a special IHS task force developed a physician recruiting strategy for the future. The resulting plan, a compilation of specific activities with estimated costs, received the full endorsement of the IHS Director in August 1986. The IHS Director allocated an additional $1.5 million of fiscal year 1987 funds to begin implementation of the recruiting plan, which raised the total recruiting program budget to nearly $4 million. No new staff positions were approved for the headquarters recruiting program.

IHS recruiters believe that if they can recruit at least 160 to 175 of the 200 new physicians needed in each of the next few years, IHS should be able to maintain adequate staffing for its current system. This is a critical point, however, because if physicians are lost more rapidly than now is anticipated, and are not replaced, it could create extreme shortages that would cause remaining staff to leave, possibly forcing facility and program closures. As it is, IHS recruiters state that the 200-per-year target takes into account physician retention rates of only about 5 percent. With retention rates as low as these, IHS must plan to replace a quarter to one-third of its total physician workforce each year.

Since IHS cannot offer competitive salaries, and the whole range of benefits, facilities, and living conditions, it is unlikely that new physicians will locate into IHS sites without an improvement in recruitment and retention options.

A special concern was voiced by Tribes and Indian organizations that more opportunities must be developed for Indians to enter into the health professions. Many of the current federal or state programs which enhance opportunities for students to enter the health professions are not specifically directed at meeting the needs of Indian students. The Indian Health Service also experiences constraints in this area due to limited resources and lack of sufficient recruiting personnel. The Committee believes that if the problems of clinical staffing shortages are to be addressed on a long term basis it is vital that concentrated efforts be made to draw more Indians into the IHS.

A study assessing the supply, geographic and specialty distribution of American Indian physicians is presently being conducted by the University of Oklahoma, in conjunction with the Association of American Indian Physicians. According to preliminary findings there are approximately 300 Indian physicians in the U.S. At least 60% or 180 are now actively providing direct clinical, or contract, care in IHS, tribal or urban Indian health facilities or may be providing indirect services in a consulting capacity or serving on tribal or urban Indian health boards. This figure is somewhat redeeming, however, it must be noted that only 20 of these physicians are actually working for the Indian Health Service.

During the process of developing S. 1475, IHS staff, (including a group of several field doctors), recommended that efforts to resolve the chronic staffing shortage must focus on two areas: developing recruitment incentives to replace the NHSC scholarship program for clinical staff, and improving personnel opportunities to enhance staff retention.

III. Legislative History

S. 1475 was introduced in the Senate on July 9, 1987 by Senator Melcher for himself and Senators Inouye and Burdick. Senators Baucus, Conrad, Shelby, Reigle, DeConcini, Mitchell, Daschle, Bingaman and Evans are cosponsors. S. 1475 was referred to the Select Committee on Indian Affairs for consideration. The Committee held a hearing on S. 1475 on August 6, 1987 in Washington, D.C. and a field hearing was held in Billings, Montana on August 25, 1987. The Committee ordered reported the bill as amended on September 25, 1987.

Two other bills in the 100th Congress address the issue of staff shortages within the Public Health Service: S. 1158 sponsored by Senator Kennedy and Senator Hatch, and H.R. 1327 sponsored by Representative Waxman. S. 1158 was passed by the Senate on July 7, 1987 and by the House on September 9, 1987. The House struck the Senate language and substituted the House language which reauthorizes the NHSC program and referred the bill back to the Senate. Each of these bills establish a Loan Repayment Program under the Public Health Service. S. 1475 differs in limiting the loan repayment program to the Indian Health Service. S. 1475 also has retention and education benefits which the other bills do not include. There is no companion bill to S. 1475 in the House.

The House version of the FY 1988 appropriations bill (H.R. 2712) includes authorization and appropriations for three elements of S. 1475: the Loan Repayment Program ($2 million); reimbursement for spousal travel for recruitment (such sums are as necessary); and Federal Tort Claim Act liability coverage for tribal and urban Indian contractors of IHS facilities and medical programs. The Senate version of the same appropriations bill also authorizes these measures with the exception of excluding contractors under the "Buy Indian" legislation for tort liability coverage. However, neither the House nor the Senate has considered authorizing legislation for these activities.

IV. Committee Actions

The Indian Affairs Committee, in open business session on September 25, 1987, by unanimous vote and with a quorum present, recommends that the Senate pass S. 1475.

V. Section-by-Section Analysis and Discussion

TITLE I—INDIAN HEALTH SERVICE LOAN REPAYMENT PROGRAM

Sec. 101. This section directs the Secretary of HHS, acting through the Indian Health Service, to establish an educational Loan Repayment Program for the Indian Health Service and tribal and urban contractors of IHS programs as a recruitment mechanism to ensure an adequate supply of doctors, nurses and other health care professionals.

The section also establishes eligibility requirements for participation in the Loan Repayment Program which include one of the following: (1) enrollment as a full-time student in the final year of a course of study determined to be needed by the Service, in an accredited institution; or (2) enrollment in a graduate training pro-

gram approved by the Secretary; or (3) possessing a degree in medicine or other health profession approved by the Secretary of (4) being employed by the IHS in a voluntary capacity in a position which qualifies for the program without an obligated service benefit; and (5) eligibility for appointment to the Commission Corps or civil service.

The Committee believes that an advantage of the Loan Repayment Program is the ability to recruit professionals in the specialty areas needed by the Service who are available for immediate employment. A disadvantage of the National Health Service Corps was the time differential between enrollment in the program and availability for employment which could be as long as seven years.

The section also describes the application process; establishes Indian preference; describes the contractual terms incumbent upon the Secretary and the participants; clarifies that the Secretary's obligation for loan repayment is contingent upon available appropriations; clarifies that the Secretary shall not make loan repayments on behalf of an individual until the participant is a full-time employee; specifies that loan repayment for each individual participant may cover tuition, fees, and other reasonable educational expenses; and provides that the Secretary may pay up to $25,000 of loan repayment for each year of obligated service. However, it is the intent of the Committee that the Secretary may exercise discretion in determining the amount of annual loan repayment for each individual by considering such factors as professional shortages, the relative difficulty in recruiting for specific locations, etc. The Secretary is also directed to submit annual reports to the Congress on the utilization of the Loan Repayment Program.

Sec. 102. This section authorizes the Secretary to recruit health professionals at accredited schools for the Loan Repayment Program and clarifies that interagency detail of personnel shall not apply to individuals in the Loan Repayment Program (that is they can only work for IHS).

Sec. 103. This section provides that the obligated service under the program requires full-time clinical practices. It also provides the Secretary with the authority to determine whether the service is to be completed as a civil service employee or as a member of the Commission Corps. This section also provides for a deferral of the beginning of obligated service for those individuals who are pursuing advanced training in areas listed in this section until such time as the training is completed but not to exceed three years. This section also clarifies the various conditions under which the obligated service formally begins. The Committee notes that the advanced training opportunity is to be available to all professions and shall not be limited to physicians.

Sec. 104. This section describes the conditions which constitute a breach of contract and the consequences for breach of contract by a participant which would include: failure to maintain satisfactory academic progress on the part of a student who is enrolled in the program; failure to complete the degree agreed upon in the contract; suspension or expulsion from school, or failure to begin or complete the term of obligated service. This section provides a formula for recovery of funds and damages from individuals who are determined to be breach of contract. The formula is the same one

used in the NHSC Scholarship Program and requires a heavy penalty for failure to comply with the contract. It is based on the premise that a stiff penalty is necessary to deter participants from opting to seek better paying jobs rather than completing the obligated service. This section also gives the Secretary authority to waive the penalty in warranted circumstances: upon the death of an individual, if circumstances would make it unconscionable for the Secretary to collect damages; or in case of bankruptcy.

Sec. 105. This section requires the Secretary to submit an annual report to Congress on the projected clinical staffing needs of the Indian Health Service for three prospective years and the corresponding projection for use of the Loan Repayment Program and the use of the Loan Repayment Program in the previous fiscal year.

Sec. 106. This section authorizes such sums as are necessary for the Loan Repayment Program.

TITLE II—OTHER RECRUITMENT AND RETENTION PROVISIONS

Sec. 201. This section authorizes the Secretary to reimburse prospective employees and their spouses for reasonable expenses incurred in traveling to and from an IHS area for recruitment purposes and authorizes appropriations of $100,000 for this purpose. The Committee believes that this will aid the IHS in recruitment because in the past, spousal dissatisfaction with a service location has been a major factor in employee attrition. In addition, the private sector makes a concerted effort to recruit the spouse as well as the physician, particularly in rural areas where there are limited job opportunities, housing or educational facilities for spouses and families of health professionals.

Sec. 202. This section directs the Secretary to award grants to Indian Tribes and organizations to develop and demonstrate innovative techniques in IHS clinical staff recruitment and retention and authorizes $600,000 in annual appropriations for this purpose. The Secretary is directed to establish regulations for the competitive awarding of these grants. The intent of the Committee is to encourage more tribal involvement and cooperation with the Indian Health Service in recruitment and retention of IHS personnel. During hearings on the bill, the need for more tribal participation in encouraging doctors and other health care professionals to locate and stay in reservation communities was stressed. The intent of the grants is to enable tribes to develop innovative techniques involving the community to compliment IHS recruitment and retention efforts and to develop local support to encourage physicians and other health care providers to continue their employment with the IHS after their service obligation is completed.

Sec. 203. This section directs the Secretary to establish an educational program for IHS employees to provide instruction in the history and culture of the tribe(s) served by a particular IHS facility and in the history of the IHS. The Service is encouraged to utilize tribally controlled community colleges to provide such instruction and to consult with tribal governments in the development of appropriate curriculum. Such sums as are necessary are authorized for the program. A major complaint by Indian people is that the

health care professionals know little or nothing about the history, culture and social conditions on reservations which affect health care and the attitudes towards IHS. The Committee believes that this program will enhance the delivery of health care and improve employee understanding of the patients served by the Indian Health Service, thereby improving relationships between health professionals and Indian people and their communities.

Sec. 204. This section directs the Secretary to maintain the Native American health career recruitment program known as the "Indians Into Medicine Program" at the University of North Dakota unless the Secretary determines that the program fails to meet the purposes of the program. The Secretary is also authorized to make at least two additional grants on a competitive basis to colleges or universities for the purpose of expanding the program model. The objectives of the INMED program are specified in this section providing the first statutory authorization for the INMED program which has been funded in the past through the appropriations process. The purpose of the INMED program is to recruit more Native Americans into the health professions.

The Committee believes that the INMED program model has been successful in both recruiting Indian students and providing appropriate support for students enrolled in schools of medicine, nursing, and other health professions at the University of North Dakota. The North Dakota program serves the states of North Dakota, South Dakota, and Montana and the Committee intends that the program model be expanded to other geographic locations in the nation which are in proximity to substantial Indian populations. The Committee encourages the Secretary to utilize the existing INMED program staff on a consultant basis, when appropriate, in activities undertaken to expand the model program. The availability of these three health careers opportunity programs is not intended to dimish the responsibility of the HHS' Bureau of Health Professions in providing assistance to Indian people to enter the health professions. The Health Careers Opportunity Program should continue to assist Indian students from disadvantaged backgrounds to enter and graduate from health professions and allied health professions schools. This section also requires the Secretary to submit a report to the Congress within 3 years of passage with recommendations for expanding or changing the INMED program.

There are authorized to be appropriated such sums as may be necessary to carry out the provisions of this section.

Sec. 205. This section authorizes the Secretary, acting through the IHS, to award grants to community colleges for the purpose of establishing health professional training programs for the benefit of Indian people who want to work in clinics and hospitals on Indian reservations. A principal reason for the limited number of Indians entering the health professions stems from inadequate education, skills and preparation in areas of math and sciences. An equally important factor for insufficient staffing of Indian professionals can be attributed to inadequate local support, training and curriculum availability. This section will initiate the development of localized and accredited community college programs to address these needs. This section proposes the development of coordinated agreements between the designated community colleges and four

year university based medical-health science programs, to enable the transition of Indians into professional degreed programs. It should be emphasized that these agreements need to include the proper sanctions necessary to approve field placements and internships within local IHS clinics and hospitals. As noted in Sec. 204, the availability of this program should not diminish the responsibility of the Bureau of Health Professions in providing Health Careers Opportunity services to Indian students.

Sec. 206. This section directs the Secretary to establish a program to enable long-term employees of the IHS to take leaves of absence to pursue advanced medical research or training at medical schools or facilities in research areas which will benefit the Service. The Committee intends that employees participating in this program would continue to receive their normal salary while on leave, but would not receive any additional funding or support from IHS. On the other hand, individuals would not be precluded from applying for scholarships, fellowships or other funding which is intended to support research or advanced training. During the hearing process, it was brought out that many physicians in remote rural areas face "burn out" and that a sabbatical or leave of absence would be helpful for longe-term staff retention. The Secretary is also directed to prescribe the necessary regulations for carrying out this section. Such sums as may be necessary are authorized to be appropriated to carry out the provisions of this section.

Sec. 207. This section directs the Secretary to provide special incentive pay (currently authorized as discretionary pay under the Public Health Service Act) to medical officers who are assigned to positions within the Indian Health Service which are hard-to-fill or for which personnel retention is a problem. The Committee notes that the Secretary has had the discretion to pay this bonus for several years, but in spite of chronic staffing shortages, which are higher in areas of extreme rural isolation, the bonus has not been used. Therefore, this section makes the bonus, which has an upper limit of $8,000, mandatory as a recruitment and retention measure.

In addition, this section requires the Secretary to develop a list of all positions other than medical officers within the Indian Health Service for which recruitment and retention are difficult, including clerical, administrative and technical positions. As a recruitment and retention measure, the Secretary shall pay a bonus of up to $2,000 per year to any employee who accepts employment in one of the positions on the list for at least one year. Unlike the retention provided for medical officers provided under section 208, this section does not require that such bonus be paid at the beginning of each year of obligated service. However, it is the intent of the Committee that such bonus payments at the beginning of a year of obligated service should not be precluded. The Committee notes that the staffing shortage within IHS is not limited just to clinical professionals and there are areas of the country where an additional incentive may be necessary to attract staff for the range of positions necessary to run an IHS hospital or facility.

This section also requires the Secretary to establish programs allowing for flexible or compressed work schedules. The committee believes that this may be an additional incentive for recruitment and retention of professional staff.

Finally, this section requires the Secretary to submit a report to Congress within six months of passage of the Act on the subject of overtime compensation for clinical staff. At present, the IHS imposes an annual limitation on the amount of overtime compensation which clinical staff may earn. This cap is frequently reached by the majority of physicians and nurses within the first six months of each year, resulting in a considerable amount of overtime work without compensation. This is a major source of staff dissatisfaction and a significant contributing factor to the high rate of staff burnout and turnover. Because of the uncalculated budget impact of removing the annual overtime limitation on local IHS service unit budgets, the Committee believes it is necessary to have an analysis of the overtime pay issue prior to directing a change in this area of personnel compensation. It is the intent of the Committee to revisit this issue in conjunction with other proposals for changing IHS personnel compensation.

The substitute amendment authorizes appropriation of such sums as may be necessary to carry out the provisions of this section.

Sec. 208. This section directs the Secretary to establish a retention bonus program for medical officers who have worked for the Service for a substantial period of time (assumed to be 3 years or more) and who sign a contract to continue employment with the IHS for an additional period of time (at least 1 year). The Secretary is directed to establish the amount of the bonus for each contract (within a range of $12,000–$25,000 per year) depending upon shortages within the Service and to provide higher rates of bonus for multi-year contracts and other circumstances. The bonus would be paid in one lump sum at the beginning of the period of service, with provision for recovery of the bonus plus interest if the service is not completed.

The retention bonus is designed to overcome the wide disparity in pay which exists between the Indian Health Service and other potential employers of IHS staff such as other Federal agencies (the Veterans' Administration, for example) and the private sector. Primarily, the bonus is designed as a retention incentive and is designed to provide an immediate financial reward to clinical staff who commit to an extended period of employment with IHS. The bonus may prove more attractive to employees if it is provided as an immediate lump sum payment. The Committee intends that the Director of the Indian Health Service be afforded maximum flexibility in determining the amount of each individual bonus to accommodate individual circumstances, shortages and relative difficulty in recruiting for specific positions and specialties and so forth.

The substitute amendment authorizes appropriation of such sums as may be necessary to carry out the provisions of this section.

Sec. 209. This section directs the Secretary to establish a 3-year demonstration project in two IHS facilities to test the feasibility of utilizing foreign medical graduates to assist in the delivery of health care. The section establishes specific conditions under which the project is to be conducted. The IHS must provide adequate supervision and training; the participants must meet specific eligibil-

ity requirements; work is to be assigned according to individualized capabilities and must be conducted under the supervision of a licensed physician. The IHS is required to report to Congress after three years with recommendations for future expansion or implementation of the project. The Committee notes that the utilization of foreign medical graduates is a controversial subject. IHS testified that foreign medical graduates have had a checkered success rate within the agency. The purpose of the demonstration project is to test the viability of utilizing a small number of foreign medical graduates who meet specific qualifications in a very small and controlled setting to determine if there are conditions under which these personnel could be utilized to offset the critical staffing shortage within the agency.

The substitute amendment authorizes appropriation of such sums as may be necessary to carry out the provisions of this section.

Sec. 210. This section requires the Secretary to establish an advisory panel comprised of 10 physicians or other health professionals, 3 representatives of tribal health boards, and 1 representative of an urban Indian health care organization to conduct a study on employee recruitment and retention issues. This study shall assess policies, procedures and barriers which impede the recruitment and retention of health professionals by the IHS and is to be submitted to Congress recommending changes in law, policy and regulations. It is the intent of the Committee that there be strong Indian representation on this advisory panel and the Committee recommends that at least five of the physicians or other heatlh professionals selected be of Indian or Alaska Native ancestry.

This section specifically provides that the study to be conducted shall address the regulatory changes that may be necessary to establish pay and salary schedules for IHS health professionals, either in Commissioned Corps or Civil Service status, which are consistent with those offered by the Veterans' Administration. These salaries shall correspond to the pay grades established for positions provided under sections 4103 and 4104 of Title 38, United States Code relating to the Veterans' Administration. It is the Committee's view that health professionals in the IHS should receive the same level of pay as those employed in other Federal agencies.

The study is to be completed no later than 18 months after date of enactment and submitted to Congress for further deliberation.

Sec. 211. This section will allow Indian tribes or tribal organizations having contracts with the Secretary of HHS to operate IHS facilities or run health delivery programs to be covered by the Federal Tort Claims Act. The Federal Tort Claims Act protects medical professionals employed by the Federal government by providing that only the Federal government can be sued for damages resulting from the performance of a Federal employee's duties. Under current law, medical professionals employed by tribes that contract for the administration of Indian health programs are not covered by the Act, requiring tribal organizations to carry medical malpractice insurance.

Within the last three years premiums for tribal malpractice insurance have sky-rocketed, rising from approximately $400,000 in

1984, to nearly $2 million in 1987. The IHS projects that these premiums could rise to as much as $6 million per annum in the near future. Contractors under Public Law 93-638 have covered these costs through direct and indirect contract funds. The concern of the Committee is that these costs are diminishing either the funds available to provide direct health care services or contract support funds available to the tribes. Under the authority of Public Law 93-638, tribes assume the Federal responsibility for delivery of health care. The Committee does not believe that tribal contractors should bear a greater financial burden for malpractice coverage than does the Federal government. In addition, the malpractice coverage issue, if not addressed in a manner which brings relief to 638 contractors, will be a disincentive for additional contracting of IHS programs.

This provision would make filing suit against the Federal government the exclusive remedy, eliminating a tribe's need for malpractice insurance. The Congressional Budget Office has no basis for estimating the additional liability that might be taken on by the Federal government or the additional cost that might be incurred by the Justice Department for defending more cases. CBO notes that while this provision would increase the Federal government's exposure to liability, Federal costs for obtaining tribal liability insurance as an indirect cost component of contract agreements would be reduced. While there are still some unresolved claims, since 1984 the actual claims paid for alleged malpractice under tribal contracts with IHS has been approximately $15,000.00.

Sec. 212. This section provides the definitions of terms used in the Act, these terms include: "the Secretary"; "the Service"; "Indian"; "Indian tribe", "tribal organization", and "urban Indian organization."

VI. Cost and Budgetary Considerations

The cost estimates for S. 1475 as provided by the Congressional Budget Office are outlined below:

U.S. Congress,
Congressional Budget Office,
Washington, DC, October 5, 1987.

Hon. Daniel K. Inouye,
Chairman, Select Committee on Indian Affairs,
U.S. Senate, Washington, DC.

Dear Mr. Chairman: The Congressional Budget Office has prepared the attached revised cost estimate for S. 1475 as ordered reported by the Senate Select Committee on Indian Affairs on September 25, 1987.

If you wish further information on this estimate we will be pleased to provide it.

With best wishes,

Sincerely,

Edward M. Gramlich,
Acting Director.

CONGRESSIONAL BUDGET OFFICE COST ESTIMATE

1. Bill number: S. 1475.
2. Bill title: None.
3. Bill status: As ordered reported by the Senate Select Committee on Indian Affairs on September 25, 1987.
4. Bill purpose: To establish an effective clinical staffing recruitment and retention program, and for other purposes.
5. Estimated cost to the Federal Government:

[By fiscal years, in millions of dollars]

	1988	1989	1990	1991	1992
Estimated authorization level					
Loan Repayment Program	2.5	5.0	6.8	6.8	6.8
Recruitment Program	.3	.3	.3	.3	.3
Travel expenses	.1	.1	.1	.1	.1
Tribal demonstration	.6	.6	.6	.6	.6
Tribal culture and history	1.0	(1)	(1)	(1)	(1)
INMED Program Advanced training and research	2.6	5.5	5.8	6.1	6.4
Incentive pay	.6	.6	.6	.6	.6
Retention bonus Foreign medical graduate demonstration	.4	.4	.5		
Advisory panel	(1)	(1)			
Grants to community colleges	2.0	2.1	2.2	2.3	2.4
Total estimated authorization level	14.3	18.9	21.2	21.1	21.6
Total estimated outlays	11.2	17.3	20.5	21.1	21.6

[1] Less than $50,000.

The costs of this bill would fall within budget function 550.

Basis of estimate.—This bill would authorize several new activities for the Indian Health Service. Except for travel expenses and tribal demonstration programs, which both would be authorized at a specific amount, the bill either would authorize such sums as may be necessary or would provide no explicit authorization to carry out the activities described. For these activities, authorization amounts have been estimated by CBO and are described below. All authorized amounts are assumed to be fully appropriated at the beginning of each fiscal year. Outlays are estimated using spendout rates calculated by CBO on the basis of similar program data.

The bill would create a new loan repayment program for physicians serving in the Indian Health Service (IHS). The federal government would make payments on outstanding educational debt up to $25,000 for each year of obligated service for individuals serving two years or more in the IHS. The program also would be available to current IHS employees. Under current law, some obligated service is performed for the IHS through the National Health Service Corps (NHSC). The historical average for length of service in the NHSC is about 2.7 years which, if assumed for this type of obligated service, would make the government payment per participant about $67,500. If the program supports 100 new participants each year the cost to the federal government would be about $2.5 million in 1988 increasing to about $6.8 million in 1990 and beyond. Cost to the federal government for the loan repayment program would very depending on the number of individuals actually participating and on their financial status.

The Secretary of Health and Human Services would be authorized to recruit for the loan repayment program at health professions schools. The federal government currently runs a recruitment program for teachers of the handicapped at an annual cost of about $0.3 million. Recruitment costs for the loan repayment program are expected to be similar.

S. 1475 would also allow tribal organizations having contracts with the Secretary of HHS to be covered by the Federal Tort Claims Act. The Federal Tort Claims Act protects medical professionals employed by the federal government by providing that only the federal government can be sued for damages resulting from the performance of a federal employee's duties. Under current law, medical professionals employed by tribes that contract for the administration of Indian health programs are not covered by the Act, requiring tribal organizations to carry medical malpractice insurance. This provision would make filing suit against the federal government the exclusive remedy, eliminating a tribe's need for malpractice insurance. This provision would increase the federal government's liability. However, CBO has no basis to estimate the additional liability that would be taken on by the federal government or the additional cost that might be incurred by the Justice Department for defending more cases. This provision also could reduce federal costs to the extent that tribal malpractice insurance currently is paid for by the federal government as an indirect cost component of contract agreements. These malpractice costs, however, are unknown.

The bill would authorize a program to educate all IHS employees serving particular tribes on the history and culture of those tribes and on the history of the IHS. The instruction would be provided through tribally-controlled community colleges. Bill language does not specify the extent of this instruction. Tuition costs per class at a sampling of tribally-controlled community colleges average about $100 per student per academic quarter. If all IHS employees were required to take one course on tribal cultures and history, costs would be about $1 million in fiscal year 1988. Costs would be lower in future years as only new employees would require instruction.

The Indians into Medicine (INMED) program is reauthorized and expanded by the bill. In fiscal year 1987, the INMED programs at the University of North Dakota received $323,000. The bill would continue this program and provide funding for at least two additional programs. Costs for three such programs are expected to be $1.0 million in fiscal year 1988 increasing to $1.2 million by 1992.

The bill would authorize the Secretary of Health and Human Services to enable IHS health professionals to "pursue advanced training or research at medical schools, or other professional schools" in areas where a need exists, as determined by the Secretary. It is not clear if this would simply allow for flexible part-time employment or leaves-of-absence for IHS employees or if educational costs would actually be paid for by the government. For this estimate, health professionals are assumed to be granted fellowships for their educational costs . . in the graduate professional fellowship programs within the Department of Education. Costs also reflect the assumption that over time, participation rates in this pro-

gram would equal the average rate for health professionals pursuing advanced degrees.

A three-year demonstration program would be authorized by the bill to train at least 10 foreign medical graduates in IHS hospital facilities. The graduates would be trained to receive licenses as physician assistants (PA's). Since these foreign medical graduates are already doctors in their own countries, PA training is assumed to last one year rather than the average of 15 to 24 months. If 10 foreign medical graduates participates in the demonstration program each year, costs to the federal government would be about $0.4 million in fiscal year 1988 increasing to $0.5 million by 1990. These costs are based on average training costs and salary for PA's.

The bill would provide an annual incentive bonus for certain medical officers if they serve in positions for which retention or recruitment has been designated as difficult by the Secretary of HHS. An estimated 300 such hard to fill positions exist. The bill would limit the bonus to $2,000 annually resulting in additional costs to the federal government of about $600,000 in each fiscal year.

Annual retention bonuses would also be provided for certain medical officers who agree to serve at least one additional year in the IHS. Annual bonuses ranging from $12,000 to $25,000 would be available to officers who have been employed by IHS at least three years or who have completed a scholarship or loan repayment obligation. Using data on officer ranks and service obligations, this provision could result in annual bonuses paid to some 175 medical officers at an average award of $18,500 resulting in costs of about $3.2 million in each fiscal year.

The bill would also provide grants to community colleges to promote health professions education. There are over 1,300 community colleges in the United States including those that are controlled by the tribes. Most have health professions programs and would be eligible for these grants. This estimate reflects an assumption that grants would be provided primarily to the 20 tribally-controlled community colleges at the levels stated in the bill for fiscal year 1988. Costs in fiscal year 1989 and beyond reflect the 1988 level adjusted for inflation.

6. Estimated cost to State and local government: None.

7. Estimate comparison: None.

8. Previous CBO estimate: On September 28, 1987 CBO prepared a cost estimate on S. 1475 as ordered reported from the Senate Select Committee on Indian Affairs. That estimate inadvertently left out of the table showing the estimated cost to the federal government the estimate for the grants to community colleges.

9. Estimate prepared by: Carmela Dyer.

10. Estimate approved by: C.G. Nuckols (for James L. Blum, Assistant Director for Budget Analysis).

VII. Regulatory Impact Statement

Paragraph II(b) of rule XXVI of the Standing Rules of the Senate requires each report accompanying a bill to evaluate the regulatory and paperwork impact that would be incurred in carry-

ing out the provision of the bill. The Committee believes that S. 1475 will have minimal regulatory or paperwork impact.

VIII. Executive Communications

The Committee received a written communication from the Department of Justice dated September 24, 1987, regarding the tort claims liability provision in Section 211 of the bill. The only communication received from the Department of Health and Human Services was in the form of prepared testimony Dr. Everett R. Rhoades, Director, Indian Health Service, presented to the Committee at its hearing on August 6, 1987. The letter and statement follow.

U.S. Department of Justice,
Office of Legislative Affairs,
Washington, DC, September 24, 1987.

Hon. Daniel K. Inouye,
Chairman, Select Committee on Indian Affairs,
U.S. Senate, Washington, DC.

Hon. Daniel J. Evans,
Select Committee on Indian Affairs,
U.S. Senate, Washington, DC.

Dear Senator Inouye and Senator Evans: We are informed that an amendment similar to a provision of H.R. 2712 may be offered at the Committee's markup of S. 1475 on September 25, 1987. The amendment reportedly would treat certain contractors of the Indian Health Service as federal government employees for purposes of the Federal Tort Claims Act. The Department of Justice is strongly opposed to any provision similar to that contained in H.R. 2712 for reasons that are fully set forth in the enclosed letter to Senator Stennis, Chairman of the Senate Committee on Appropriations. We urge the Select Committee on Indian Affairs to reject any such amendment at the markup on S. 1475.

Sincerely,

John R. Bolton,
Assistant Attorney General.

U.S. Department of Justice,
Office of Legislative and Intergovernmental Affairs,
Washington, DC, September 21, 1987.

Hon. John C. Stennis,
Chairman, Committee on Appropriations,
U.S. Senate, Washington, DC.

Dear Mr. Chairman: As you know, the Committee on Appropriations will soon consider fiscal year 1988 appropriations legislation for the Department of the Interior in the form of H.R. 2712. I am writing you this letter to inform you of the strong opposition of the Department of Justice to a provision contained in that legislation which would deem certain contractors of the Indian Health Service to be employees of the federal government for the limited purpose of having the United States assume their liability under the Federal Tort Claims Act for their medical malpractice.

The relevant provision in H.R. 2712 provides in pertinent part:

> [S]ection 103(c) of the Indian Self-Determination Act (88 Stat. 2206) is amended by adding the following sentence at the end thereof: ". . . with respect to claims for personal injury, including death, resulting from the performance of medical, surgical, dental, or related functions, including the conduct of clinical studies or investigations, a tribal organization or Indian contractor carrying out a contract, grant agreement, or cooperative agreement . . . is deemed to be part of the Public Health Service in the Department of Health and Human Services while carrying out any such contract or agreement and its employees (including those acting on behalf of the organization or contractor as provided in section 2671 of title 28) are deemed employees of the Service while acting within the scope of their employment in carrying out the contract or agreement."

H.R. 2712, 100th Cong., 1st Sess., 62-63 (1987). Virtually identical language was included in fiscal year 1987 appropriations legislation for the Department of the Interior (H.R. 5234), but was deleted in the Senate.

For sound policy reasons, the Department of Justice has consistently opposed legislation which would make the United States liable for the torts of its contractors. Under the Federal Tort Claims Act (FTCA), the United States accepts limited responsibility for the actions of those persons with whom it has a "master-servant" relationship, and over whom it can exert direct control—that is, its employees. Neither of these relationships generally exists between the United States and its contractors.

As a rule, the United States has no ability to review, supervise, or control the day-to-day conduct of its contractors. This fact of life does not change simply by deeming them to be "employees" for purposes of the FTCA. To impose liability upon the United States for conduct it cannot supervise and control, and thereby effectively to immunize contractors from the consequences of their tortious conduct, is both fiscally unwise and potentially counterproductive to improved health care among the Indian tribes.[1]

The rationale offered for this legislation has been the projected difficulty in obtaining qualified medical personnel to provde health services to the Indian tribes in the face of rising medical malpractice insurance premiums. But the crisis in medical malpractice insurance is by no means isolated. It affects the provision of health care across the Nation, and can best be addressed by the implementation of specific tort reform measures designed to make the civil justice system work in a reasonable and predictable manner; [2] not

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[1] While the Secretary of Health and Human Services has limited discretion to determine whether to enter a particular contract or agreement with a tribal organization, *see* 25 U.S.C. § 450g, there intentionally is no built-in system to monitor the everyday administration of those contracts or agreements. The reason for this, of course, is to provide the maximum degree of self-governance to the Indian tribes. It follows that to impose liability upon the United States for conduct it cannot supervise and control, and to immunize contractors from the consequences of their tortious conduct, is both fiscally unwise and potentially counterproductive to improved health care amoung the Indian tribes.

[2] In this regard, we would refer to a report on medical malpractice recently issued by the Department of Health and Human Services' medial malpractice task force.

by effectively immunizing a small class of affected physicians over whom the government has at best limited control.

Moreover, there is nothing unique about the liability problems facing physicians. The crisis in affordable and available liability insurance has affected all manner of manufacturers and providers of goods and services. The Administration's Government Contractor Liability Reform Act of 1986 (S. 2441, 99th Cong. 2d Sess.) was designed to improve the liability insurance climate for all government contractors without unnecessarily opening the door to the public treasury. In the absence of such reform, however, providing special status and protection for contractors of the Indian Health Service is unjustified and inequitable.

Numerous providers of goods and services to the government could make equally compelling arguments that their situations deserve the same special consideration which H.R. 2712 would provide to physicians contracting with the Indian Health Service. In this regard, we are extremely concerned about the possible consequences for other contractor physicians. As you know, the Department of Defense and the Veterans Administration, in particular, use many contractor physicians. With few exceptions, these contractor physicians—who are not employees of the federal government—remain responsible for their acts of medical malpractice. See *Lurch* v. *United States,* 719 F.2d 333 (10th Cir. 1983). It is likely, should this provision be enacted, that these contractor physicians will demand similar treatment to that afforded Indian Health Service contractor physicians. Indeed, for certain contractor specialities, such as obstetricians/gynecologists, the malpractice insurance crisis may be far more acute than that currently facing most Indian Health Service contractor physicians.

In addition, this provision runs directly counter to the fundamental concept of Indian self-determination. It is inconsistent to endorse the notion that the Indian tribes should be self-governing and in control of their welfare, while at the same time relieving them and their contractors of responsibility for their negligence.

Finally, we note the inadvisability of attaching this provision to appropriations legislation. Such a context often will not sufficiently accommodate the debate and discussion required by such a substantive and controversial provision. In this regard, we note that a similar provision is contained in H.R. 1223, the "Indian Self-Determination Amendments of 1987," which is currently awaiting action in the House. The Department is equally opposed to that legislation for the reasons outlined above. Nevertheless, H.R. 1223 seems a far better vehicle for full consideration of the issue.

In sum, the Department of Justice opposes creating a special class of government contractors effectively immunized from responsibility for their tortious conduct. Accordingly, we strongly urge that the above-cited provision be deleted from H.R. 2712. The Office of Management and Budget has advised that there is no objection to the submission of this report from the standpoint of the Administration's program.

Sincerely,

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(For John R. Bolton, Assistant Attorney General).

STATEMENT OF EVERETT R. RHOADES, M.D., DIRECTOR, INDIAN HEALTH SERVICE

Mr. Chairman and Members of the Committee: I am Dr. Everett Rhoades, Director of the Indian Health Service (IHS). I am pleased to be here today to discuss with you S. 1475, a bill which would address some of the problems associated with recruitement and retention of health personnel within the IHS.

We recognize certain recruitment and retention problems at the Indian Health Service and we are already carrying out a number of actions to alleviate these problems. Although some of the provisions in S. 1475, such as the loan repayment program would address IHS personnel requirements, other provisions raise numerous problems regarding civilian and uniformed services personnel systems. We object very strongly to the bill's provisions establishing or applying new incentives for General Schedule personnel in the Indian Health Service that are not generally applicable to Federal civilian employees. As a result, the Administration cannot support S. 1475 in its present form.

In Senator Melcher's statement on July 9, introducing S. 1475, he noted the recent special report of the Office of Technology Assessment (OTA) on "Clinical staffing in the Indian Health Service," and indicated that this bill was intended, at least in part, to implement recommendations made by OTA. Dr. Robert E. Windom, Assistant Secretary for Health, Public Health Service (PHS), testified on April 30 on the OTA report before the House Committee on Interior and Insular Affairs. In his testimony, Dr. Windom noted that the report clearly presents the current situation in IHS. He also pointed out that while the problem is one of recruitment and retention of physicians in the Indian Health Service, it is linked also to the broader problem of availability and distribution of health professionals.

In addition, Dr. Windom described some of the efforts that are already underway in IHS to deal with health professionals recruitment and retention. In summary, the IHS has developed a recruitment plan in conjunction with the Health Resources and Services Administration (HRSA) to provide health professionals for underserved areas, including the IHS. The plan includes funds for clerkships, journal ads, conference displays, site visits, and prospective candidate travel. Additional initiatives include a Medical School Advocate Program, a long-term training program for residents, and development of a recruiting videotape. As you can recognize, much effort is already being expended, though much remains to be done.

In addition to these various individual activities aimed at improving IHS recruitment and retention of health professionals, I would also like to underscore the PHS Commissioned Corps revitalization now underway. Surgeon General Koop has implemented this revitalization with the goal of making the Commissioned Corps more effective. An

important component of this plan will be to increase the mobility of the over 5,000 Commissioned Corps health professionals, many of whom already serve in the IHS. As noted in the recent OTA report, the PHS Commissioned Corps is an elite mobile force whose officers are subject to reassignment to meet public health needs and emergencies. We anticipate that the revitalization underway will greatly enhance our ability to strengthen placement of additional Commissioned Corps officers in IHS priority locations.

S. 1475 would authorize a loan repayment program permitting IHS to recruit individual health professionals, including students in their final year of professional school. In exchange for a period of obligated service, IHS would be required to repay a certain amount of the students educational loans. Other provisions of the bill would also authorize grants for tribal demonstration projects in recruitment and retention; require training in Indian history and culture to IHS clinical staff; maintain and replicate the Indians into Medicine Program (IMED); provide various incentives for existing clinical staff to stay with IHS; require IHS to investigate the possibility of using foreign medical graduates as physician assistants; and establish an in-house review panel to evaluate IHS policy and procedure impacting on recruitment and retention.

As expressed in a July 9, 1987, letter from Secretary Bowen to the Chairman of the Senate Labor and Human Resources Committee, we believe that a loan repayment program would be an improvement over the current scholarship program of the National Health Service Corps. We believe that such a program makes good sense and would help address the unique recruitment needs of the IHS. Unlike scholarship programs, a loan repayment program could provide health professionals quickly to help fill vacancies in the IHS and would provide a timely, effective, and economical means of recruiting health professionals for service to meet priority needs, while allowing maximum flexibility in targeting the program from year to year.

Section 201 would authorize IHS to use funds to pay for spouse travel, when the spouse is accompanying an applicant for an IHS position to his/her prospective employment site. No other prospective Federal employees are granted spouse travel benefits, and we believe this provision would create an undesirable potentially costly precedent.

Section 203 would require all employees serving specific tribes to receive instruction in the history and culture of such tribes. Instruction would, to the extent feasible, be under the auspices of the tribes served. We favor increased participation of tribal governments in recruitment and retention efforts and make efforts to orient our employees to the culture of the tribes that they serve. However, we be-

lieve that the aspect of making instruction mandatory might be viewed by some as a disincentive to recruitment.

Section 204 would require IHS to maintain the INMED Program at the University of North Dakota and to replicate the program at a number of other schools through a competitive grants process. More study should be undertaken before replication in other, often different, environments should be legislated. The proposal does not adequately describe what it is that should be replicated. In addition, it would be inconsistent not to require INMED also to compete. Based on INMED's experience, it would have no problem competing for its grant in the future. Also, we do not believe separate regulations should be required, but rather that reliance should be placed on grant regulations that are in place.

Section 205 would establish a program to support advanced training and concomitant research at medical schools for IHS staff. The IHS existing recruitment plan already allows for allocating increased resources for continuing medical education. In addition, each year residency training in family medicine and other selected specialties will be sponsored by IHS for Commissioned officers. Current officers will be given preference for residency training in order to improve retention. Once the training is completed, these physicians will be assigned to hard-to-fill sites as determined by the IHS. This program is in its first year. We plan to select up to 25 physicians for this program in 1987, 12 of whom were selected on April 15 of this year. Since present training requirements for Civil Service employees limit long-term training to 2 years, section 205 would equalize the opportunity available to employees in both systems and provide additional flexibility by allowing longer residencies for Civil Service employees.

Section 206 proposes various "Additional Incentives". PHS statutory authorities currently permit the PHS to establish "incentive special pay" for medical officers serving in the Commissioned Corps. Section 206(a) would mandate use of, and expand this authority to include Civil Service medical officers in IHS and requires its implementation for hard-to-fill locations or shortage specialties. As Assistant Secretary for Health Windom previously testified, implementation of "incentive special pay" for Commissioned medical officers serving in hard-to-fill IHS assignments or who have specialties for which the IHS has a difficult time recruiting, e.g., orthopedics, ENT, radiology, urology, and child psychiatry, is under active consideration, but for pay to Commissioned Officers, not to civilians who are not covered by military pay laws.

Since HHS already has authority to grant incentive special pay, and is currently examining this matter, there is no need to statutorily require payment of a bonus. It is important to maintain administrative flexibility in personnel matters, and we believe that the incentive bonus should remain discretionary. The differing purposes and require-

ments of the uniformed and civil services necessitate differing personnel policies for the two distinct systems. It is inappropriate to merge or mix these two systems. Any deficiencies in the civilian personnel system should be corrected through that system.

A more appropriate vehicle for providing bonuses to address the recruitment and retention problems in the IHS is the Physicians Comparability Allowance (PCA), scheduled for reauthorization this year. As of March 31, 1986, 85 civilian IHS medical officers were already receiving physicians comparability allowances. The Department believes that the PCA should be reauthorized, and that the current $10,000 ceiling on his bonus payment, which has declined in value since its enactment in 1978, should be increased. The Administration will soon advance reauthorization legislation for the PCA to the Congress, proposing that the ceiling be raised to $20,000 as we have recommended.

Section 206(b) would establish an incentive bonus with a maximum of $2,000 for designated IHS health care professionals other than medical officers. In addition to the problems noted above, we do not believe the bonuses are either necessary or justified for use except as already authorized for physicians. Moreover, section 206(c), requiring the Secretary to establish a flexitime program, when flexitime is already allowed, is unnecessary. Section 206(d), providing for unlimited overtime for professional health care employees, is inappropriate and costly.

Section 207 creates yet another new retention bonus for both Commissioned Corps and civilian IHS employees, and sets a $12,000 floor on annual bonus payment to individuals. The criticisms of new bonuses stated earlier are equally valid here, but let me reiterate that it is important to maintain the distinctions between the uniformed and Civil Service systems. Moreover, while some change in the health professional compensation system may be necessary, the PCA is the appropriate mechanism for addressing the issue, not the creation of yet another special bonus. Even if a new bonus were warranted, a $12,000 per annum floor is excessive and could inappropriately give additional pay to IHS staff not in a position with a recruitment or retention staffing shortage.

In summary, we strongly oppose the miscellaneous array of bonuses and special pays proposed in S. 1475. The title 5 special rate authority already available to IHS, and the Administration's proposed Civil Service Simplification Act proposal, introduced as S. 1545, would, for instance, permit special rates on the basis of undesirable geographic location, something which would be particularly valuable to IHS for both physicians and non-physicians.

We also oppose section 208, which would establish a limited demonstration program to investigate the possibility of using foreign medical school graduates (FMSG) in IHS as physician assistants. We have serious doubts as to the need for this program, as IHS has very limited need for

physician assistants. We also question whether someone with the background required by the bill would be willing to function as a physician's assistant.

In dealing with this issue, I must first emphasize that we are unwilling to relax standards for high quality care and I am happy that the bill reflects a similar commitment. It should be noted that we can currently hire FMSGs as physicians but they must have successfully completed one year of an AMA-approved internship or residency. In addition, the bill requires that an FMSG must be proficient in the English language and, if not a citizen, have residency status. The language proficiency requirement is critical since a FMSG with a poor command of English would have a most difficult time with many IHS beneficiaries for whom Emglish also would not be their native language. It would, perhaps, be a better use of limited resurces to provide funding for a special number of AMA approved training programs for FMSGs to qualify as physicians in exchange for an IHS service obligation.

Section 209 would establish an advisory panel made up primarily of IHS health professionals to assess impediments to recruitment and retention and suggest improvements to Congress. We do not believe the establishment of an advisory panel is required. The causes of recruitment and retention problems in IHS are well known and were well documented in the recent OTA report.

Section 210 would change the eligibility date for early retirement of non-Indian employees of the IHS and the Bureau of Indian Affairs from December 21, 1972, to December 5, 1979. This latter date is the date of passage of the Indian Civil Service Retirement Act, Public Law 96–135, which made Indian preference applicable to reduction in force and, therefore, changed the conditions of employment applying to non-Indians in these agencies who were appointed before the date of enactment. We are considering the impact of this provision on our agency; the Department of the Interior is doing likewise. We will be happy to advise the Committee as soon as we have developed a position on this section.

Section 211, as provided with your letter of invitation, would extend medical malpractice coverage of the Federal Tort Claims Act (FTCA) to cover certain Indian contractors. The IHS is undertaking a study of the number of medical malpractice suits filed against tribal organizations contracting to carry out IHS functions under the Indian Self-Determination Act and the cost of malpractice insurance paid for out of IHS contract funds. We will be happy to share this study with the Committee when it has been completed.

That ends my prepared statement. We will be happy to attempt to answer any questions you may have.

IX. MINORITY VIEWS OF MESSRS. EVANS, McCAIN, AND MURKOWSKI

We have joined with our distinguished colleagues in unanimously approving S. 1475, a bill to improve the clinical staffing problems in Indian Health Service. However, we have serious concerns about one particular section of the bill that we do not believe will offer a long-term and permanent solution to the critical shortage of qualified physicians and other medical personnel. That provision, Sec. 209 of S. 1475, authorizes the Foreign Medical Graduate Demonstration Project.

The clinical staffing shortages within the Indian Health Service are indeed problematic and will require comprehensive and localized solutions to address this critical issue. For the most part, S. 1475 offers solutions that adhere to the cultural sensitivity of Indian people and are aimed at long term objectives. Providing second class health care, even on a demonstration basis, does nothing to solve the problem.

We do not believe that a demonstration project which utilizes foreign medical doctors will be in the best interests of Indian people. A study conducted by the University of Washington clearly showed that the use of foreign medical doctors is risky at best. Factors which contribute to this are inconsistency in training and incomplete knowledge of the adequacy of foreign medical schools. Some schools may be very good, and some not so good, the problem remains that it is not known precisely the nature of how adequate these programs are in graduating qualified physicians.

The National Indian Health Board which represents all of the tribes in the 12 areas of the Indian Health Service strongly opposes this provision. NIHB has stated that foreign medical graduates have particular difficulty in adjusting to cultural and language differences on Indian reservations. Further, it is believed that these foreign nationals lack the communication and medical skills necessary to provide quality health care.

In addition, the Association of American Indian Physicians also strongly opposed this provision, as noted in testimony which was received as part of the hearing record.

It is stated that the Foreign Medical Graduates who are placed within this program will receive close supervision by an accredited physician. How will this be possible if current IHS physicians are already overburdened? How can Indian people be assured that this supervision will be effective? It is clearly perceived that these factors will only compound the problem and that the quality of care provided to Indian people will suffer.

We agree that Indian people deserve the best quality health care. Already the Indian Health Service is faced with delivering quality health care on a limited budget, and the use of foreign doctors only compounds the problem.

DANIEL J. EVANS.
JOHN MCCAIN.
FRANK H. MURKOWSKI.

X. Changes in Existing Law

In compliance with subsection 12 of rule XXVI of the Standing Rules of the Senate, the Committee notes the following changes in existing law made by S. 1475 (existing law proposed to be omitted is enclosed in black brackets, new matter is printed in italic, existing law in which no changes are proposed is shown in roman).

Subsection (c) of section 103 of the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450g(c)) is amended as follows:

(c) [The Secretary] *(1) The Secretary* of Health and Human Services is authorized to require any tribe requesting that he enter into a contract pursuant to the provisions of this subchapter to obtain adequate liability insurance: Provided, however, That each such policy of insurance shall contain a provision that the insurance carrier shall waive any right it may have to raise as a defense the tribe's sovereign immunity from suit, but that such waiver shall extend only to claims the amount and nature of which are within the coverage and limits of the policy and shall not authorize or empower such insurance carrier to waive or otherwise limit the tribe's sovereign immunity outside or beyond the coverage and limits of the policy of insurance.

(2) For purposes of section 224 of the Public Health Service Act (42 U.S.C. 233(a)), and chapter 171 and section 1346 of title 28, United States Code, with respect to claims for personal injury, including death, resulting from the performance of medical, surgical, dental, or related functions, including the conduct of clinical studies or investigations, an Indian tribe, tribal organization, or Indian organization carrying out a contract, grant agreement, or cooperative agreement under this section or section 104(b) of this Act, the Act of April 30, 1908 (35 Stat. 71; 25 U.S.C. 47) is deemed to be part of the Public Health Service of the Department of Health and Human Services while carrying out such contract or agreement and its employees (including those acting on behalf of the organization or contractor as provided in section 2671 of title 28) may, if provided in the contract, grant agreement or cooperative agreement at the request of the Indian tribe, tribal organization, or Indian organization, be deemed employees of the Service while acting within the scope of their employment in carrying out the contract or agreement.

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